

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE  1190 E 2900 North Road Clifton, IL 60927	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</b></p> <p>Based on observation, interview, and record review the facility failed to sufficiently staff housekeepers to maintain a clean and homelike environment for five of seven residents (R1, R2, R5, R6, R7) reviewed for housekeeping in the sample list of seven.</p> <p>Findings include:</p> <p>On 1/22/25 at 5:15 AM there was a white dusty substance on the floor outside of the B Hall Shower Room door. From 6:17 AM to 6:35 AM V8 (Housekeeper) cleaned the front entrance of the facility. V8 did not sweep prior to mopping the floor. At 6:41 AM V8 emptied the garbage cans at the nurses' station and mopped the floor. V8 did not sweep the floor prior to mopping. At 8:30 AM V8 cleaned and mopped resident rooms and bathrooms at the beginning of the C Hall. V8 used a broom to sweep up a pile of debris after V8 had finished mopping. V8 did not take a toilet brush into the bathroom to clean the toilet. At 8:43 AM V8 stated if there is only one housekeeper scheduled V8 only has time to clean V8's assigned two halls and then rotates and cleans the other remaining two halls the next day. V8 stated there has been days when only one housekeeper was scheduled, especially on the weekends. V8 stated V8 only uses a toilet brush to clean the inside of the toilets when they are visibly dirty and not every day. V8 stated V8 does not sweep prior to mopping to save time.</p> <p>On 1/22/25 between 9:08 AM and 9:19 AM V10 (Housekeeper) and V9 (Housekeeper orientee) were cleaning rooms at the end of A Hall. V9 and V10 did not sweep the entire room floor prior to mopping. At 9:28 AM V10 stated resident rooms, bathrooms, and toilets are supposed to be cleaned daily. V10 stated there should be two housekeepers divided up between the four halls, but on the weekends, there has only been one which makes it difficult so only two of the four halls are cleaned, and the other halls are cleaned the next day. V10 stated V10 only sweeps the floors prior to mopping if they are bad.</p> <p>1.) On 1/22/25 at 8:06 AM R2 stated the housekeepers don't come into clean R2's room every day, it's usually every other day. R2 stated not all the housekeepers sweep prior to mopping or clean the toilets. On 8:17 AM R1, R2's roommate, stated housekeeping doesn't do a thorough job of sweeping and cleaning R1's room.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. R1's MDS dated [DATE] documents R1 as cognitively intact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R1's Concern/Compliment Form dated 1/15/25 documents R1 had concerns with housekeeping not cleaning the bathroom, not emptying the trashcan, and not thoroughly mopping and cleaning R1's room.</p> <p>2.) On 1/22/25 at 9:38 AM R7 stated housekeeping does not clean R7's room daily and they only sweep/mop as one. R7 stated R7's room has not been cleaned today. There was a dried brown substance on R7's toilet. At 12:10PM there was debris on R7's room floor and R7's toilet remained dirty. R7 stated no housekeeping staff had been in to clean R7's room today. R7 stated the housekeepers should sweep prior to mopping, but they don't. R7 stated R7 records on a calendar when R7's room is cleaned. This calendar did not document R7's room was cleaned on 1/2/25-1/7/25, 1/9/25, 1/10/25, 1/12/25, 1/14/25, 1/15/25, 1/18/25, 1/19/25-1/22/25.</p> <p>R7's MDS is dated 12/12/24.</p> <p>R7's Concern/Compliment Form dated 12/17/24 documents R7's room was not being swept or mopped and the bathroom wasn't being cleaned. R7's Concern/Compliment Form dated 1/7/25 documents R7 had concerns that R7's room was not cleaned appropriately and there was debris on the floor.</p> <p>On 1/22/25 at 12:18 PM V10 stated they had not been down to clean B Hall (where R5 and R7 reside) yet today and was unsure if V10 would have time to clean that hall prior 2:00 PM when V10's shift ends.</p> <p>3.) On 1/22/25 at 11:46 AM R5's toilet seat had a brown dried substance and there was a dark area on the inside bottom of the toilet bowl.</p> <p>4.) On 1/22/25 at 7:46 AM the inside of R6's toilet bowl had rust colored stains.</p> <p>On 1/22/25 at 10:07 AM V17 (Certified Nursing Assistant) stated the housekeepers haven't been sweeping the floors prior to mopping and the toilets don't get cleaned every day unless you tell them there's a problem.</p> <p>On 1/22/25 at 10:37 AM V19 (Housekeeping/Maintenance Supervisor) stated daily cleaning schedule includes resident rooms, bathrooms, shower rooms, and dining rooms. V19 stated the housekeepers should be sweeping the floors prior to mopping and bathrooms should be cleaned daily from top to bottom, including the toilets. V19 confirmed there have been problems with this not getting done. V19 stated we had been short staffed in housekeeping and just recently hired V9 who started on 1/20/25. V19 stated every couple of days we only had one housekeeper scheduled so not all the resident rooms were getting cleaned daily and we had to alternate between the halls. V19 stated we are supposed to have two housekeepers scheduled each day.</p> <p>The facility's housekeeping schedule dated 1/5/25-2/1/25 document only one housekeeper was scheduled on 11 days between 1/5/25 and 1/19/25.</p> <p>The facility's undated Cleaning Process documents to disinfect or clean housekeeping surfaces such as floors on a regular basis and when visibly soiled and toilets should be cleaned at least daily.</p> <p>The facility's undated Detailed Cleaning Check Off List documents to clean/vacuum under all the beds and dressers and sanitize and disinfect the commodes thoroughly.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40385</p> <p>Based on observation, interview, and record review the facility failed to sufficiently staff Certified Nursing Assistants (CNAs). This failure affects five of seven residents (R1, R2, R3, R5, R7) reviewed for staffing in the sample list of seven. This failure has the potential to affect all 71 residents in the facility.</p> <p>Findings include:</p> <p>On 1/22/25 between 2:44 PM and 3:03 PM V18, V28, V29, V30, and V31 were the only CNAs working in the facility.</p> <p>1.) On 1/22/25 at 7:55 AM R3 stated the facility doesn't have enough staff as the staff are constantly running. R3 stated if the CNAs are on their lunch break, then you must wait about 30 minutes for someone to answer your call light. R3 stated R3 is incontinent, uses the call light to be changed, and must wait for staff assistance.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact and requires substantial/maximal staff assistance for toileting.</p> <p>2.) On 1/22/25 at 8:06 AM R2 stated the facility is short staffed and it takes about 20-30 minutes for staff to answer R2's call light.</p> <p>R2's MDS dated [DATE] documents R2 as cognitively intact and requires partial/moderate staff assistance for most Activities of Daily Living.</p> <p>3.) On 1/22/25 at 8:17 AM R1 stated the facility does not have enough CNAs they cut down to having one CNA per hall and a float for days and evenings. R1 stated R1 has waited for over an hour for R1's call light to be answered when R1 needed incontinence care. R1 stated R1 must wait when the CNAs are on their lunch break as well.</p> <p>R1's MDS dated [DATE] documents R1 as cognitively intact and R1 is dependent on staff for toileting assistance.</p> <p>4.) On 1/22/25 at 9:38 AM R7 stated the facility doesn't have enough CNAs they are always running in and out and in a hurry when providing cares. R7 stated R7 waits up to an hour for R7's call light to be answered on day shift when R7 is waiting for incontinence care.</p> <p>R7's MDS dated [DATE] documents R7 is dependent on staff for toileting assistance.</p> <p>5.) On 1/22/25 at 11:46 AM R5 stated there aren't enough staff, when R5 asks the CNAs to do things they tell R5 that they don't have time. R5 stated sometimes R5 waits an hour for R5's call light to be answered, and R5 pointed to the clock in R5's room and stated there's a clock right there for me to see. R5 stated sometimes R5 must wait for incontinence cares.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R5's MDS dated [DATE] documents R5 requires substantial/maximal staff assistance for toileting.</p> <p>The facility's Facility assessment dated [DATE] documents the facility's staffing needs are six CNAs on day shift, five CNAs on evening shift, and three CNAs on night shift.</p> <p>The facility's Weekly Schedule dated 1/5/25-1/25/25 documents the following: there were five CNAs for evening shift on 1/11/25, 1/14/25, 1/19/25 and 1/20/25 and there were five CNAs for day shift on 1/19/25.</p> <p>The facility's Daily Census dated 1/9/25 documents a census of 77 residents. The facility's Daily Census dated 1/21/25 documents a census of 71 residents.</p> <p>On 1/22/25 at 5:03 AM V3 (CNA) stated there have been times where night shift had three CNAs within the last few weeks, which is a lot for 70 residents.</p> <p>On 1/22/25 at 8:40 AM V14 (CNA) stated we are supposed to have six CNAs on dayshift, but there are times we have worked with less than that and it's hard. V14 stated call light response times are affected which could affect timely toileting requests.</p> <p>On 1/22/25 at 10:07 AM V17 (CNA) stated V17 feels rushed and short cuts, such as not applying lotion after showers and quick morning care, are taken when there are five CNAs working. V17 stated call light response times are affected when there are only five CNAs working.</p> <p>On 1/22/25 between 2:44 PM and 3:03 PM the following interviews were conducted:</p> <p>V28 (CNA) stated there should be six CNAs working tonight, but we have worked with four and five CNAs within the last few weeks. V28 stated that isn't enough, showers don't get done and call lights are affected. V28 stated we don't even get to take our breaks, but we do the best that we can. V29 (CNA) stated we usually work with six CNAs, but there has been five or less recently. V29 stated we do the best we can but call lights might not be answered as quickly. V30 (CNA) stated we usually work with five or six CNAs, which is not enough based on the acuity of the residents not just the census. V30 stated care falls behind, showers don't get done, toileting and incontinence cares are delayed, and call lights are affected. V30 stated there was one weekend when only four CNAs worked, and the same care was affected. V30 confirmed there were only five CNAs working second shift tonight. V30 stated V30 is the B and D Hall float and will try to float to the other halls as well, but most of her time will be spent on B Hall since that is the heaviest hall. V31 (CNA) stated second shift is supposed to have six CNAs but V31 just found out there are five working tonight. V31 stated we have worked with five and V31 feels rushed and not enough time to give the residents that they deserve. V31 stated showers don't get done and it is difficult to keep up with the call lights. V31 stated some residents are incontinent because they had to wait too long for assistance. V31 stated our charting doesn't get done and we don't get our breaks. V31 stated there are a lot of residents that require two assist and mechanical lift transfers.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/22/25 at 3:11 PM V2 (Director of Nursing/DON) stated the facility likes to staff six CNAs on day and evening shifts, but sometimes evenings has five. V2 stated the facility staffs four CNAs on night shift. V2 stated V25 (Scheduler) determines the staffing and does the schedules. V26 (Assistant DON) stated staffing is based on the census and the census was up to 76 within the last two weeks. V2 and V26 confirmed five CNAs were currently working the evening shift today. V26 provided a copy of residents' transfer status and stated the facility requires two persons to operate the mechanical lifts. This list documents 28 of the 71 residents require two person assist for transfers.</p> <p>On 1/22/25 at 3:26 PM V25 stated V25 uses a staffing ladder to determine the number of CNA hours to provide based on acuity needs, which is not resident acuity needs but more so the activities that are scheduled for the CNAs each shift such as dayshift is responsible for getting residents up verses night shift is just doing rounding and a list of residents assigned for get ups. V25 stated the CNA staffing based on census of 71 residents is 126 hours of CNA coverage which is 16 CNAs per day. V25 stated a census of 75 residents is 133 CNA hours and 17 CNAs per day. V25 confirmed this staffing calculator is based on resident census and does not factor in the acuity needs of the residents. V25 stated the 16-17 CNAs needed per day is scheduled as six on days, six on evenings, and four on nights. V25 stated V15 (Restorative CNA) is pulled to work the floor any time there is less than six CNAs Monday through Friday. V25 stated 77 residents was the highest census on 1/8/25. V25 verified the weekly CNA staffing reports provided were accurate.</p> <p>On 1/22/25 at 4:48 PM V1 (Administrator) confirmed the Facility Assessment has not been updated since August 2024 and V1 stated it needed to be updated.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40385</p> <p>Based on observation, interview, and record review the facility failed to sufficiently staff dietary support personnel resulting in delayed timeliness of meals for four of seven residents (R1, R2, R3, R4) reviewed for dietary services in the sample list of seven. This failure has the potential to affect all 71 residents in the facility.</p> <p>Findings include:</p> <p>On 1/22/25 between 6:50 AM and 12:20 PM V32 (Dietary Manager) worked as the dayshift cook during the breakfast and noon meals. V22 and V23 (Dietary Aides) were the only other kitchen staff working in the morning. All resident meals were served to resident rooms due to the facility experiencing gastrointestinal illnesses.</p> <p>On 1/22/25 at 10:55 AM V32 (Dietary Manager) was setting up the steam table to begin serving the noon meal. At 12:00 PM the A, B, and C Hall meal trays were delivered. At this time staff began delivering the D Hall trays to resident rooms, including R1 and R2.</p> <p>1.) On 1/22/25 at 7:46 AM R4 stated there was a day about a week ago that breakfast wasn't served until 9:00 AM due to something happening in the kitchen.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] documents R4 as cognitively intact.</p> <p>2.) On 1/22/25 at 7:55 Am R3 stated there was one day that breakfast wasn't served until 9:00 AM.</p> <p>R3's MDS dated [DATE] documents R3 as cognitively intact.</p> <p>3.) On 1/22/25 at 8:06 AM R2 was eating breakfast in R2's room. R2 stated breakfast was served late today and R2's meal tray was delivered at 7:50 AM. R2 stated there was one day that the noon meal wasn't served until 12:00 PM.</p> <p>R2's MDS dated [DATE] documents R2 as cognitively intact.</p> <p>The facility's Mealtimes dated 4/29/24 documents room trays are served at 7:00 AM for breakfast, 11:00 AM for lunch, and 4:45 PM for supper.</p> <p>V24's (Cook) Timecard dated 12/22/24-1/8/25 documents V24 clocked in at 5:14 AM on 12/22/24, 5:16 AM on 12/24/24, 6:09 AM on 12/26/24, 5:20 AM on 1/5/25, 5:31 AM on 1/6/25, 5:29 AM on 1/7/25, and 5:25 AM on 1/8/25.</p> <p>The facility's dietary schedules dated 12/22/24-2/1/25 document the following: The morning cook hours are 5:00 AM to 1:30 PM and V24 was scheduled as the facility's morning cook for the dates listed above on V24's timecard.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/22/25 at 9:58 AM V12 (Licensed Practical Nurse) stated there was one day about two weeks ago that breakfast wasn't served until 9:00 AM due to an issue in the kitchen. V12 stated blood glucose was checked for diabetic residents and nutritional shakes were given prior to breakfast being served that day.</p> <p>On 1/22/25 at 10:07 AM V17 (Certified Nursing Assistant) stated there was one day that the cook didn't show up on time, so breakfast wasn't served until close to 9:00 AM.</p> <p>On 1/22/25 at 12:57 PM V20 (Cook) stated we had a cook, V24, who would always show up late for work or sit in his car for an hour at a time, so breakfast and lunch were served 30 minutes and up to an hour late, which happened two or three times. V20 stated one time lunch was not served until 1:30PM-2:00PM due to breakfast being served late at 9:00 AM. V20 stated the dietary department has been short staffed recently and V20 is the only dayshift cook and only works part time.</p> <p>On 1/22/25 at 12:20 PM V32 (Dietary Manager) stated V24 (Cook) was hit and miss with reporting to work on time and V24 recently quit on 1/8/25. At 1:15 PM V32 stated 45 minutes past the scheduled mealtime is not considered timely. V32 stated today the D Hall meal trays did not leave the kitchen until 11:45 AM because staff kept coming back to ask for things. At 2:11 AM V32 stated V24's shift was 5:00 AM to 1:30 PM and verified V24's late clock ins on V24's timecard. At 4:56 AM V32 stated V32 works Monday-Friday from 8:30 AM until 4:30 PM, but V32 worked as the dayshift cook on 1/9/25, 1/10/25, 1/13-1/19/25. V32 stated V32 worked as the dishwasher on 1/6/26 and 1/7/25 since there was no one else scheduled. V32 stated V32 was off work from 12/25/24-12/28/24, 1/1/25, 1/3/25, 1/5/25 and 1/8/25.</p> <p>The facility's Daily Census dated 1/21/25 documents 71 residents reside in the facility.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>40385</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on interview and record review the facility failed to maintain food ordering and supply to ensure the menus are followed and to log substitutes. This failure affects three of seven residents (R1, R2, R5) reviewed for dietary services in the sample list of seven and has the potential to affect all 71 residents in the facility.</p> <p>Findings include:</p> <p>On 1/22/25 at 8:06 AM R2 stated the facility runs out of food and doesn't always have substitutes available.</p> <p>On 1/22/25 at 8:17 AM R1 stated the facility has run out of milk, orange juice, and dinner rolls.</p> <p>On 1/22/25 at 11:46 Am R5 stated the facility has run out of certain foods and R5 is not always served yogurt with her meal.</p> <p>The facility's Week at A Glance Menu Week 2 documents cheeseburger on a bun as the main entree for the evening meal on Sunday (1/5/25) and sweet and sour pork as the main entree on Thursday (1/9/25) as sweet and sour pork.</p> <p>The facility's food order invoices dated 12/2/24, 12/23/24 and 12/30/24 document three boxes of 40 beef patties were ordered for each invoice. The facility's food order invoice dated 1/20/25 documents four boxes of 40 beef patties were ordered. There is no documentation that beef patties were ordered after 12/30/24 until 1/20/25.</p> <p>On 1/22/25 at 12:34 PM V21 (Cook) stated we run out of hamburgers, and we were without hamburgers for a month prior to this weeks' food order delivery. V21 stated we run out of meat because only half of the amount needed is ordered and therefore smaller portions are served rather than the correct serving size.</p> <p>On 1/22/25 at 12:57 PM V20 (Cook) stated the facility runs out of food a lot and often doesn't have the food listed on the menu to serve. V20 stated the facility has been without hamburger patties for a month, occasionally runs out of chicken breasts, and smaller portions/ounces of food and meat have been served due to not having enough supply to meet the serving requirement. V20 stated V20 must improvise and come up with something else to serve. V20 stated sometimes the kitchen staff doesn't have the food prepped or set out for thawing prior for the following morning. V20 stated V20 must get the food out to thaw first thing in the morning in hopes that it will be thawed to cook for the noon meal or V20 must find something else to serve. V20 stated for example V20 has had to serve fish sticks instead of fish and recently sweet and sour pork was served in smaller portions due to not having enough. V20 stated V20 asks V32 what foods to use in place of the foods that aren't available. V20 was unsure if the substitutions are logged anywhere and thought this was done by V32 (Dietary Manager).</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 1/22/25 at 10:55 AM V32 stated the main entree was bratwurst burger patties with sauteed peppers and onions, and fajita chicken or hamburger on a bun were the main entree substitutes that were available for the noon meal.</p> <p>On 1/22/25 at 12:20 PM V32 and V20 (Cook) stated hamburgers is something that is offered as an always available substitute. At 1:15 PM V32 removed a binder from her door that contained a substitution log. The Menu Substitution Form indicates to log scheduled food item, substitution item, the reason for the substitution and the employee and dietitian's signature. This last recorded entry prior to 1/22/25 was 9/4/24, and this was confirmed with V32. V32 stated the staff should be logging substitutions on the log so that the dietitian can sign off and approve the changes. V32 stated chicken was used a substitute for the sweet and sour pork to have enough servings. V32 stated V32 uses the recipes as a guide to determine the quantity of food to be ordered and always rounds up. V32 stated hamburger patties were not ordered this month due to not being in the budget. V32 stated food orders are placed every Friday and delivered on Tuesdays.</p> <p>On 1/22/25 at 1:34 PM V27 (Registered Dietitian) stated V27 is in the facility one day per week and substitutions should be logged for V27 to review and approve. V27 stated V27 would have concerns if the staff weren't providing substitutes of equal amounts of an equivalent food to prevent weight loss. V27 stated V27 was not aware that the facility had been running out of foods or that smaller portions were being served.</p> <p>The facility's Daily Census dated 1/21/25 documents 71 residents reside in the facility.</p> <p>The facility's undated [NAME] and Kitchen Staff Orientation documents to use this guide to train the cooks, the menus/recipes must be followed, and any changes must be signed off by the dietitian and kept.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE  1190 E 2900 North Road Clifton, IL 60927	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</b></p> <p>Based on observation, interview, and record review the facility failed to ensure substitutes were available and failed to honor residents' food preferences for six of seven residents (R1, R2, R3, R5, R6, R7) reviewed for dietary services in the sample list of seven.</p> <p>Findings include:</p> <p>On 1/22/25 from 6:50 AM until 7:38 AM V32 (Dietary Manager) and V23 (Dietary Aide) served the breakfast meal on individual trays for each hall cart. V32 stated last week the facility was without yogurt for three days while they waited for the food order delivery. V32 stated peanut butter and toast was served in place of the yogurt while the facility was without. Yogurt was not served on R3's and R6's meal trays.</p> <p>On 1/22/25 at 12:20 PM there was no prepared egg salad readily available in the kitchen coolers. V32 stated there are hard boiled eggs that can quickly be made into egg salad if requested. V32 confirmed residents do not preselect meals. V32 stated the residents just let us know if they want something else once their meal is served.</p> <p>1.) On 1/22/25 at 7:25 AM R6 was in R6's room eating breakfast and R6's meal tray did not contain yogurt as specified on R6's meal ticket. At 11:25 AM R6 was in R6's room eating lunch and R6's meal did not include yogurt as specified on R6's meal ticket.</p> <p>R6's Minimum Data Set (MDS) dated [DATE] documents R6 has severe cognitive impairment.</p> <p>2.) On 1/22/25 at 7:55 AM R3 was eating breakfast in R3's room. R3 stated R3 likes yogurt and R3 is supposed to have it with breakfast but that doesn't happen. R3's meal ticket documents yogurt with breakfast, but there was no yogurt served with R3's breakfast.</p> <p>R3's MDS dated [DATE] documents R3 as cognitively intact.</p> <p>3.) On 1/22/25 at 8:06 AM R2 was eating breakfast in R2's room which consisted of O shaped wheat cereal with milk, yogurt, and toast. R2 stated the dietary staff don't listen and don't follow the meal tickets. R2 stated R2 doesn't always get yogurt and yesterday R2 was served broccoli which is listed as a dislike on R2's meal ticket. R2 stated R2 prefers the fruit flavored cold cereal but was served the wheat cereal. R2 stated the facility runs out of food and doesn't always have substitutes available. R2's meal ticket documents yogurt and fruit flavored cold cereal with breakfast and R2 dislikes broccoli.</p> <p>R2's MDS dated [DATE] documents R2 as cognitively intact.</p> <p>The facility's Week at A Glance Menu Week 4 documents spaghetti with meat sauce, broccoli, garlic bread, fruit crisp and beverage as the noon meal for Tuesday Day 24 (1/21/25).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  LA Bella at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE  1190 E 2900 North Road Clifton, IL 60927	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4.) On 1/22/25 at 8:17 AM R1 was in R1's room and was finished eating breakfast. R1's meal tray included a bowl of hot cereal that R1 did not eat. R1 stated R1 does not like hot cereal and is supposed to have the fruit flavored cereal. R1's meal ticket documents fruit flavored cereal every morning.</p> <p>R1's MDS dated [DATE] documents R1 as cognitively intact.</p> <p>5.) On 1/22/25 at 9:38 AM R7 was in bed in R7's room. R7's breakfast tray included cheesy eggs, pancakes, fruit flavored cold cereal, peach yogurt, and chocolate milk. R7's meal ticket documents yogurt for breakfast. R7 stated the dietary staff are not very good about giving R7 yogurt at breakfast. R7 stated there are no substitutes offered at supper other than peanut butter and jelly sandwiches, which are hard.</p> <p>6.) On 1/22/25 at 11:46 AM R5 was in bed. R5's noon meal included yogurt and R5's noon meal ticket documents yogurt to be served with lunch. R5 stated the facility has run out of certain foods and R5 is not always served yogurt with her meal.</p> <p>On 1/22/25 at 10:07 AM V17 (Certified Nursing Assistant) stated peanut butter and jelly sandwiches and egg salad sandwiches are the only alternative meal options offered. V17 stated there is an always available menu, but they don't always have those items available. V17 stated the kitchen staff don't always serve the yogurt when listed on the meal tickets.</p> <p>On 1/22/25 at 12:20 PM V32 (Dietary Manager) confirmed preferences listed on the meal tickets should be followed and confirmed the above listed meal tickets. V32 stated hot cereal should not have been served for R1 as R1 is supposed to have the fruit flavored cold cereal.</p> <p>On 1/22/25 at 12:57 PM V20 (Cook) stated sometimes there are no hard-boiled eggs to make the egg salad listed on the always available menu. V20 stated the egg salad should be made up ahead of time to be readily available since we don't have time to make it once we are serving.</p> <p>The facility's Always Available Menu dated 5/20/24 lists cereal, milk/juice, scrambled egg, deli meat and cheese sandwich, egg salad, applesauce, green beans, peanut butter and jelly sandwich, and chef salad.</p> <p>The facility's undated [NAME] and Kitchen Staff Orientation documents to use this as a guide to train cooks, resident's preferences are listed on the meal cards and should be served accordingly, and the always available meals are offered, executed, have diversity, and meet the proper nutritional value.</p>		